



Level II - Invalidation Statement
DOCUMENTATION FOR INTERRUPTED EVALUATION
Billing Statement

INSTRUCTIONS: This form is to be used only when a Level II Evaluation is terminated when the evaluator finds that the person being evaluated: 1) does not meet the PASARR definition for serious illness; or 2) does meet the criteria for primary dementia, with no documentation in the medical records that the person is not seriously mentally ill, or has a primary dementia diagnosis. In this case, an Invalidation Statement should be completed, and if the evaluation is terminated after fifteen minutes or more, this Documentation for Interrupted Evaluation form, DSHS 14-413A, should be completed and attached to the Invalidation Statement, DSHS 14-413, and submitted with an A19 voucher for reduced fee. If the contracted reduced fee is requested, this form must also be signed by the contracted agency or clinical director certifying that there was no documentation in the medical records that the person being evaluated met the criteria for serious mental illness.

1. CLIENT NAME	LAST	FIRST	MIDDLE	2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH
4. FACILITY NAME					5. COUNTY

IT SHOULD BE REPORTED ON THIS FORM AT WHAT POINT THE EVALUATION WAS HALTED

<input type="checkbox"/> A face to face evaluation was begun on this person because no documentation was found in the medical records that the person did not meet the criteria for serious mental illness or did meet the criteria for dementia. The evaluation was halted after _____ minutes because the person does not have a diagnosis of developmental disability or a related condition and because he/she: (check one of the following) <input type="checkbox"/> did <u>not</u> meet the criteria for serious mental illness; or <input type="checkbox"/> <u>did</u> meet the criteria for dementia.	
DATE OF INTERRUPTED INTERVIEW	EVALUATOR'S NAME
If the interview was interrupted after fifteen minutes or more, the agency director or clinical director of the contracted agency as stated in section above must complete and sign the following for reimbursement purposes:	
EVALUATOR CERTIFICATION/INFORMATION	
AGENCY'S NAME	
PRINT PROGRAM ADMINISTRATOR'S NAME HERE	AGENCY PROGRAM ADMINISTRATOR'S SIGNATURE

Comments: